



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

J T DILGER JR MD
6718 MONTAY BAY DRIVE
SPRING TX 77389

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1990-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Designated Doctor Exam Extent of Injury...Ordering & reviewing additional diagnostic studies"

Amount in Dispute: \$570.00 + interest for 90 days

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for consideration to this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2011	99456-RE-W6	\$500.00	\$500.00
November 17, 2011	99456-VR-W5	\$70.00	\$0.00
TOTAL		\$570.00 + interest for 90 days	\$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
2. 28 Texas Administrative Code §133.240 sets out procedures for medical payment and denials.
3. Texas Labor Code §413.019 sets out procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
4. Texas Labor Code §401.023 sets out procedures for computation of Interest or Discount Rate.
5. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 15, 2011

- No denial reason codes/descriptions listed on explanation of benefits

Explanation of benefits dated January 27, 2012

- 16 – Claim/service lacks information which is needed for adjudication.
- This charge denied because an invalid code was submitted on the bill or the bill has missing or invalid required information. (X160)
- An incorrect combination of codes has been billed. Please resubmit with the correct combination of codes. (X047)

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for CPT Codes 99456-RE-W6 and 99456-VR-W5?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed the amount of \$500.00 for CPT code 99456-RE-W6 for an Extent of Injury Examination for date of service October 11, 2011. Review of the narrative documentation supports services rendered as billed. Per 28 Texas Administrative Code §134.204(i)(2)(A) and (k), the Maximum Allowable Reimbursement (MAR) for the 1st Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is \$500.00. The requestor also billed the amount of \$70.00 for CPT code 99456-VR-W5 for date of service October 17, 2011. Per 28 Texas Administrative Code §134.204(j)(6), "The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed \$50. Also, Per 28 Texas Administrative Code §134.204(n)(10) states "VR, Review report – This modifier shall be added to CPT code 99455 to indicate that the service was the treating doctor's review of report(s) only." The requestor billed using an incorrect CPT code (99456-VR-W5), therefore, is not entitled to reimbursement for this code. Reimbursement is recommended for CPT code 99456-RE-W6.
2. The respondent reimbursed the requestor the amount of \$0.00 for the disputed services and \$0.00 for interest due for CPT code 99456-RE-W6. In accordance with 28 Texas Administrative Code §134.204, the appropriate amount due is \$500.00. In accordance with 28 Texas Administrative Code §134.130, the appropriate amount due for interest is \$0.00. Therefore reimbursement amount of \$500.00 is recommended for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ May 23, 2012 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.